ESTABLISHED PATIENT HISTORY FORM

In order to provide appropriate on going care, we ask that you update your information. Please do not assume MUA has been receiving updates from your primary care physician.

Last Name ______________________ **First Name** ______________________ **Middle** ________________

Today's Date _____/_____/ ________ **Age** ______________ **Date of Birth**________/_________/_________

Mailing Address: ____

Phone: Home ____________________ **Work** _____________________ **Cell** _______________________

Primary Care Physician ____

Main Reason for today's visit:

____

Personal Medical History: please indicate whether you have had any of the following medical problems, (Please indicate with a yes or no.)

Yes No

Heart Disease: (type) ____

Do you have cardiac stents? ____ What type? ____

If yes: When was it placed and by whom? ______________________________________

Do you have a pacemaker, mechanical or replacement valve, or other implants? _______

If yes: When was it placed and by whom? ______________________________

Have you ever had a Myocardial Infarction (Heart Attack)? ______

If yes: When did you have the heart attack? ___________________________________

Do you experience Angina (Chest Pain)? ________

If yes: How do you manage the episode? ____________________________________

Who is your cardiologist? ____

Cancer (type) ____

Who is your oncologist? ____

High Blood Pressure

High Cholesterol

Diabetes (specify) type I ___ or type II ____

Cataracts

Glaucoma

Other ____

Surgical History:

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Allergies & reactions to medications:

Allergy:	Reaction:	Allergy:	Reaction:

Please list the medications and/or over-the-counter, herbal supplements, vitamins, or homeopathic intake. Medications: Prescriptions, Over-the-counter, Herbal, Vitamins, or Homeopathic: Please include: **Anti-coagulants: (Blood Thinners) including, aspirin, coumadin, (warfarin), plavix, (clopidogrel).**

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Pharmacy Name ______________________________ **Location** __________________________________
Or
Mail Order Pharmacy: ____
Fax Number: ____

Mobility:
Yes No

Are you able to walk independently?

Do you use an assistive device? ____ Cane ______ Walker ____ Wheelchair ____Scooter

If yes, can you stand and pivot? ___________________

Have you or are you experiencing any other significant health issues?

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____ _________________________
Patient or Guardian Signature **Date**

____ _________________________
Provider Signature **Date**